MONTHLY FACE-TO-FACE VISIT FORM

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
NURSING HOME TRANSITION AND DIVERSION (NHTD) & TRAUMATIC BRAIN INJURY (TBI)

[ ] NHTD Waiver
[ ] TBI Waiver

Name:	CIN:	Date:
Name of parent/legal guardian (if applicable):		
Location of Visit:		In-home*: __ Yes __ No

*One in-home visit must be conducted quarterly

The Service Coordinator should ensure that the participant has a copy of each of these documents in an easily accessible location and review each document with the participant during their face-to-face meeting:

__ Participant Rights and Responsibilities
__ Plan of Protective Oversight
__ Participant Contact List
__ ISP/RSP

ISP/ RSP Implementation:

The plan is being implemented and services are being provided as approved in the plan. __ Yes __ No

The participant reports or indicates satisfaction with the current supports and services identified in the current plan. __ Yes __ No

The person's plan is current and any changes or updates have been made this month as needed.
Please describe:

Describe any progress noted in the last month:

The person's plan requires updating or amendment and the actions needed are noted below.

Describe the overall condition of the participant, including any health concerns noted on the day of the visit. For home visits, note the general condition of the home environment. Summarize your discussion and concerns noted on the day of the visit. Attach extra documentation if necessary.

Incident Report trends, complaints and/or concerns this month needing follow-up: __ None
Explain:

Anticipated date of next face-to-face visit: _____

Anticipated location of next face-to-face visit: _____

_____ _____
Participant Signature Date

_____ _____
Legal Guardian Signature (optional) Date

_____ _____
Service Coordinator Signature Date

_____ _____
Service Coordinator Supervisor Signature Date